MEDI-CAL UPDATE Part 2
Billing and Policy
www.medi-cal.ca.gov

Outpatient Services • Chronic Dialysis Clinics

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Contents

Laboratory Service Frequency Limits Clarification

Retroactive to dates of service on or after January 5, 2004, laboratory services are subject to frequency limits. These limits are set per recipient, per service, per month via the Laboratory Services Reservation System (LSRS). Laboratory providers may use the LSRS to make reservations, or verify if a frequency limit has been reached for a specific recipient for a specific laboratory service prior to performing the procedure. When a reservation is made, the claim must be billed with the provider number used to make the reservation.

Frequency limits may be overridden on a case-by-case basis when the provider submits medical justification to support the frequency of the laboratory service for a recipient. Justification will be reviewed by medical review staff for final authorization. Providers are reminded that laboratory service claims that are denied due to frequency limitations may be appealed with submission of medical justification. Failure to make a laboratory service reservation prior to performing the laboratory service may result in denial of the claim.

The following entities are excluded from frequency limitations when the full laboratory service is rendered onsite: End Stage Renal Disease (Dialysis) Clinics, county public health clinics, Skilled Nursing Facilities (SNFs), inpatient hospitals and emergency rooms. The following programs are excluded from frequency limitations: California Children's Services, Genetically Handicapped Persons Program and Child Health and Disability Prevention Program.

Note: Providers are reminded that independent clinical laboratories that provide services to recipients in SNFs and dialysis clinics must adhere to the same requirements to supply their claims with further documentation in support of medical justification for rendering laboratory services to these recipients.

For an overview of the LSRS process, providers can go to:
http://pro.medi-cal.ca.gov/Docs/Elearning/LSRS3028/HTML/HOME.htm

This information is reflected on manual replacement page path an over 7 (Part 2).

New Blood Factor Billing Method for Pharmacy Providers Coming Soon

Effective for dates of service on or after July 1, 2006, pharmacy providers must bill Blood Factor and Anti-Hemophilia Factor products using National Drug Codes instead of billing "By Report." Providers can submit claims hard copy or electronically. However, providers who bill for California Children's Services (CCS)-only, CCS/Healthy Families, Genetically Handicapped Persons Program (GHPP)-only eligible recipients, or for Medi-Cal/CCS/GHPP-eligible recipients with a CCS or GHPP Legacy or a CCS Service Authorization Request, must continue to bill hard copy with the required authorization by the Children's Medical Services Branch.

Please see **Billing Method**, *page 2*

Billing Method *(continued)*

All other provider types must continue to bill using the "By Report" methodology currently in place using the *HCFA 1500* claim form.

Medi-Cal will continue to reimburse providers the lesser of the manufacturer's Average Selling Price plus 20 percent or the provider's usual and customary charge.

Provider manual pages regarding this policy will be updated in a future *Medi-Cal Update*.

Exceptions to Submitting CIFs

Providers are reminded not to submit *Claims Inquiry Forms* (CIFs) for the following Remittance Advice Details (RAD) code messages, unless information on the CIF specifically addresses the denial reason. For example, if the denial was 002, but an error is found in the recipient ID on the original claim, this would be an appropriate CIF, with a changed recipient ID. However, if providers wish to challenge the determination, a CIF will result in the same denial. A review by a person in the appeals unit is the only way of resolving denials if the claim has a unique circumstance needing human intervention.

Code	Message
0002	The recipient is not eligible for benefits under the Medi-Cal program or other special programs.
0010	This service is a duplicate of a previously paid claim.
0072	This service is included in another procedure code billed on the same date of service.
0095	This service is not payable due to a procedure, or procedure and modifier, previously reimbursed.
0314	Recipient not eligible for the month of service billed.
0326	Another procedure with a primary surgeon modifier has been previously paid for the same recipient on the same date of service.

The updated information is reflected on manual replacement page cif co 2 (Part 2).

CCS/GHPP SAR Exceptions Update

Effective for dates of service on or after April 1, 2006, California Children's Services (CCS) and Genetically Handicapped Persons Program (GHPP) providers need a separate Service Authorization Request (SAR) for the following drugs, factors and nutritional products:

- Anti-Inhibitors (J7198)
- Factor VIIa Recombinant (Q0187)
- Minerals/Protein Replacements/Supplements
- Sildenafil
- Tadalafil
- Vardenafil
- Von Willebrand Factors (Q2022)

In addition, effective for dates of service on or after April 1, 2006, Factor VIIa Recombinant should be billed using HCPCS code Q0187. HCPCS code Z5230 will no longer be an active code.

This updated information is reflected on manual replacement page cal child sar 6 (Part 2).

Instructions for Manual Replacement Pages Part 2

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Remove and replace:	cal child sar 5/6
Remove:	cif co 1 thru 10
Insert:	cif co 1 thru 11
Remove and replace:	medi cr op 7/8 *
	path an over 7

* Pages updated due to ongoing provider manual revisions.